Guardian

Dependent Eligibility Certification Form

General Information	
Subscriber Name:	**Policy #:**
Dependent Name:	**Dependent Date of Birth:**
Dependent Address:	
Dependent Member ID #: _____	

Student & Dependent Certification

1. **Is the child unmarried, a resident of Connecticut and not covered under another group health plan through the dependent's employer?** ☐ **YES** ☐ **NO**
2. **Is the child a full-time student at an accredited school?** ☐ **YES** ☐ **NO**
3. **If "YES", name and address of school in which dependent is enrolled:** _____

   _____
4. **Expected date of graduation (if this year):** ____ /____ /____
   MO DAY YR

Disability Certification

1. **Is dependent now incapable of self-support because of a disability?** ☐ **YES** ☐ **NO**
2. **Age of dependent when disability occurred:** _____
3. **Nature of disability (Please provide as much detail as possible):**

   _____

   _____
4. **Prognosis (estimate months or years):** _____
5. **Name and address of Primary Care Physician:** _____

   _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUEST IN REGARD TO THE CERTIFICATION.

_____ _____

Subscriber Signature **Date Signed**

Any person who includes any false or misleading information on an application for insurance commits a fraudulent insurance act and is subject to criminal and civil penalties.

Please complete this form and return to the following: The Guardian Life Insurance Company of America, P.O. Box 981569, El Paso, TX 79998-1569

GG -015024-CT DTC A9/14/18